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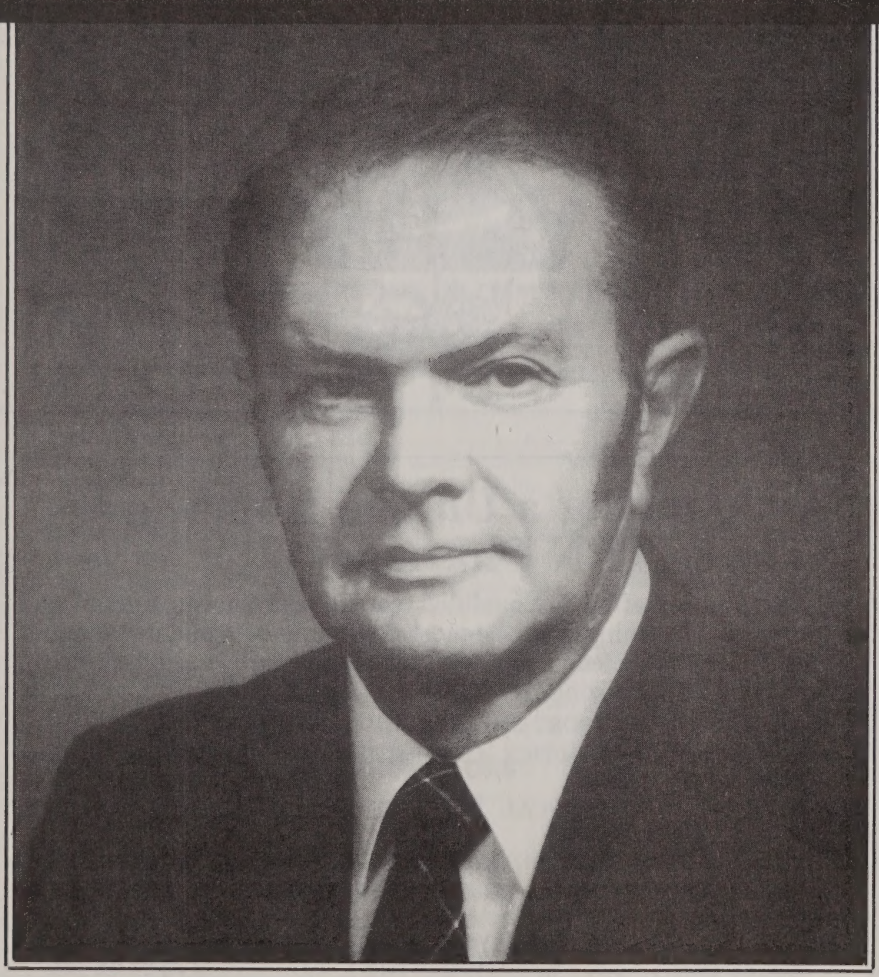

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HAMPDEN DISTRICT MEDICAL SOCIETY 1984-1985 SEASON

District Meeting

PLACE:	Sheraton-West West Springfield
DATE:	Tuesday, September 25, 1984
BUSINESS MEETING:	6:00 P.M.
SOCIAL HOUR:	7:00 P.M.
DINNER:	7:30 P.M. Spouses are welcome. Area clergy will be invited guests.
SPEAKER:	Msgr. Dino J. Lorenzetti Buffalo, New York
SUBJECT:	"Nobility Of The Physician"
CHOICE OF MEAL:	Sole Veronica or Chicken Kabobs

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Choice of Meal:

Sole Veronica_____ # of meals Chicken Kabobs_____ # of meals

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AUGUST - SEPTEMBER 1984 VOL. XXXXI NO. 14

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.

THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

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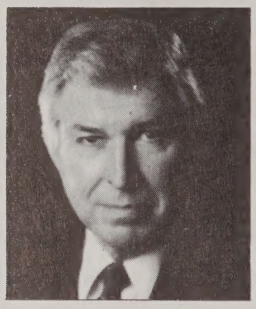

Lorne C. Smith, M.D.
President

PRESIDENT'S PAGE

Medicare Assignment

On June 23, I attended a public hearing on health care issues of the elderly. When first asked to participate, I thought I would be on a panel discussing the subject. A few days prior to the event, I was informed that my role would be to give testimony before a panel. The suggested content was to describe our (HDMS) concerns for the elderly. A number of issues were suggested. The first item of the list was Medicare assignment.

The event was most enlightening to me as an observer waiting for my turn at the microphone. The panel consisted of two state representatives, one congressman's aide, several executives employed by organizations acting on behalf of the elderly, and two elderly persons active in their affairs.

The sponsor was the Villers Foundation, a private foundation. Mrs. Villers was a member of the panel. I have no idea to whom the results of the hearing were sent if indeed any report was made. The press and TV were there and the substance of the hearing was reported in our local papers the following day.

The audience was four to five hundred elderly people bussed in from all parts of Western Mass. The tone of the affair was set by a moderator who quoted a long list of statistics blasting the health care system with a number of particularly unfavorable allegations against our profession.

His strongest statement and the audience reaction, in turn, concerned physician and other "provider" non-acceptance of assignment for services covered by Medicare.

At the same time, both the U.S. Congress and the AMA in their annual meeting, were debating the same subject — Medicare assignment. It would, in my view, then, be an appropriate subject for this column.

The substance of the Villers Foundation "Hearing" was significant in spite of the cheerleading stance of the sponsors and the enthusiastic responses on the part of the audience. Most elderly in Massachusetts live at or near the technical poverty level. Most have no flexibility in where their money goes. Recent changes in Medicare administration have made both hospital and physician coverage require larger payments by the patient. Supplemental insurance, primarily Medex, has subtly reduced some areas of coverage leaving larger gaps to

be born by the patient. There is no question (to me) that this single issue is of paramount concern to our elderly.

I told the panel and the audience that we are concerned about the rising cost of health care and that we are sensitive to the needs of the elderly. I advised that the physician can, on occasion, impact on the cost as it related to the individual patient but that most components in the rise in health care costs are not within our control and reflect the adoption of new technology and techniques to everyday practice. I emphasized that our ability to intervene meaningfully to produce longer, higher quality life for the elderly, and most patients, for that matter, has increased spectacularly during the past few years. Most of this progress has taken the form of expensive and sophisticated means of diagnosis and therapy such as CT Scanners, joint replacement, coronary and peripheral artery surgery, new, more effective medication for a spectrum of diseases, etc., all being very costly. The elderly are not excluded from access to the system.

I pointed out that in other societies - most of the rest of the world -that resource allocation to health care is limited by the goverments concerned.

The usual method of reducing costs, or in another sense using scarce resources to best advantage is to exclude the elderly from expensive, complex care. Examples cited were renal dialysis in the United Kingdom and a broader form of rationing practiced in many Eastern European countries where ambulances are not dispatched for patients over a specific age, usually 60.

I asserted that continued efforts at cost control such as Chapter 372 in Massachusetts and the DRG reimbursement method now in place in most of the country would inevitably lead to some care being unavailable. The elderly with chronic difficult health problems could in the near future find care difficult to come by.

This assertion awakened both the panel and the audience none of whom had apparently considered the possibility.

I urged the audience and their leaders to insist that political candidates, particularly those seeking national office in the House or Senate, to make their positions on the issues known and to vote accordingly.

With the exception of pediatrics and OB-GYN, most physician - patient encounters involve the elderly. Most hospitalized patients are elderly. Most operations are performed on elderly patients. All occupants of nursing homes, with rare exception, are elderly.

We must, in my opinion, be sensitive to the concerns of the elderly both as individual practicing physicians and as a society. Recognizing that each relationship between patient and physician is unique

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and personal, the following approach is recommended concerning acceptance of Medicare assignment.

1. When patient financial hardship is clearly the consequence of an additional financial burden, the physician should, in most cases, accept assignment.

2. When assignment is not accepted, the patient should be informed of this fact, in a timely manner, and, when possible, advised of the magnitude of this financial obligation that would become the responsibility of the patient.

I suspect that the approach of 1 and 2 above are followed by most members of HDMS. These suggestions have been approved by the Executive Committee of HDMS.

At the Villers hearing the wish, on the part of the elderly, for a means of learning which physicians accept Medicare assignment was expressed several times. I have presented this request to the Executive Committee and will place the matter before the membership at our September meeting.

See you in September.

Lorne C. Smith, M.D.

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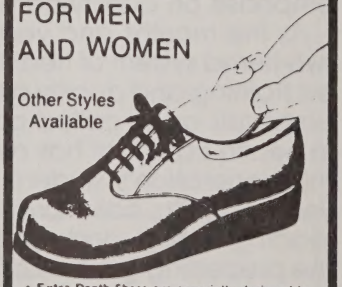

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A Message from Dr. Duncan

In this current year, let us reflect on the physician-patient relationship as provider and consumer. Are we adversaries or mutual advocates? Certainly in our private practice it is the latter, although publicly it appears to be the former. About 75% of the citizens in Massachusetts have primary care physicians. Others, particularly in the surgical specialties, have less frequent continuous contact with patients, and yet, there is a special relationship that develops from the "laying on of hands". Thus, as we render skilled care, it would appear appropriate to discuss issues of general public interest relating to health care delivery and the relationship of consumer and provider as mutual advocates rather than adversaries. The patient's interests are always of paramount importance. Individually we believe this and collectively as a medical society we must tell this to the public in its language.

Publicly, unfortunately, the relationship appears to be adversarial. This appears manifested in professional liability litigation, the apparent adverse relationships we are placed in because of the Governor's bill to ban balance billing, and the apparent adversarial relationships between the Society and state regulatory agencies and the legislature. I do believe the average citizen is not enamored of Blue Shield nor the legal profession nor the various branches of state government. Opinion polls demonstrate this. We as physicians who have the most direct contact with patients have developed close physician-patient relationships, but may have shown disdain for carefully developing and expanding our consumer advocacy position. We are concerned about quality care and an apparent de-emphasis on quality care at the state level.

As the months and years go by, we are witnessing a more formal two-tiered system of health care which appears to de-emphasize skilled training and quality almost to the point of denigration with greater emphasis on so-called cost containment. We are viewing a parallel in health care that has already been witnessed in education. Just as this generation's student is less well educated than his parent, this year's health care provider (not referring to the intense training leading to M.D. and residency programs) is far less well trained than the preceding generation. A two-tiered system of health care is evolving, by chance or by design, at the state level beginning with nursing home patients and the chronically ill, though undoubtedly it will extend to the acute care patient.

During the current year, take the time to explain your personal feelings to your patients as the Society will similarly communicate with the citizenry. An ad hoc committee is looking at potential deficiencies in Massachusetts in regards to health education. A newly appointed staff member as the Director of Education will coordinate educational activities in a variety of committees, such as; student health,

sports medicine, public and environmental health and mental health.

Our statewide health science information dissemination network, being developed and implemented by the Society with the enthusiastic pariticipation of the librarians of MaHSLiN, will enable the clinician to have immediate access to the most up-to-date medical information. This can only be of benefit to our patients using state of the art technology. This is a truly exciting developing and will impact on all physicians and patients in daily practice.

With our new headquarters, we have a physical plant in which to develop a team of skilled staff personnel to assist us in our relations with the citizenry of the Commonwealth. The Society is in the process of developing, through its Committee on Publications, exciting new programs which will impact favorably not only on our own patients, but on physicians and patients nationally and internationally.

While we physicians in Massachusetts may be discouraged by a trend which we view as potentially harmful to our patients, there are some progressive developments alluded to above. Our pessimism must be tempered with optimism and enthusiasm for new ideas.

Frederick J. Duncan, Jr., M.D.
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AMA Annual Meeting Report

Annual meetings of the House of Delegates of the AMA are now held in Chicago in June as opposed to interim meetings which are held at various sites in December. The annual meetings are one day longer to accommodate the election and inauguration process. "A-84" was held June 17-21. Delegates selected 12 council members, 2 residents, 4 trustees, and 4 officers to direct our $100 millin dollar a year activities. Massachusetts is proud to have elected to his first term as trustee Dr. Robert McAfee, a chairman of the New England caucus. It is a tribute to the democratic methods of the House that a state with only one delegate can prevail over larger delegations with greater financial resources. All the New England delegates cooperated in an austere, innovative campaign resulting in a one-vote majority on the first ballot.

Dr. Joseph Boyle of California was installed as the 1984-85 AMA president. His stirring inaugural address set the tone for the meeting as he emphasized the importance of saying no to the bureaucrats who are interfering with the delivery of medical care in the name of cost-containment. He called on all of us to continue our primary concern for the care of our patients, and rededicate ourselves to our professional ethics.

This message reflected the attitude of the delegates as they acted on the largest agenda of any meeting --- 82 reports and 184 resolutions. These covered myriad problems but the issues that raised the greatest concern were DRG's, reimbursement for cognitive services, hospital-medical staff relationships, and professional liability. Phase one of the Health Policy Agenda for the American people was received, consisting of 159 principles to be used for policy development. The House endorsed all but one of the principles, with a few modifications. This general agreement with the work of the commission reflects the care taken in establishing this process. When policy statements are developed, more conflict may be apparent. The end result should be a sound framework for difficult health care decisions facing the country.

DRG's are a threat on the Massachusetts horizon. In the rest of the country, they are a thumb-screw ready to ratchet down. New regulations are being promulgated by HCFA while the AMA is trying desparately to monitor the impact of current rules. The bureaucrats would do well to remember that most problems are caused by solutions. Opposition was voted to the algorithmic approach to DRG's, combined physician-hospital payment, expansion of prospective pricing to physicians, and arbitrary geographic criteria.

The Medicare physician attestation statement was assailed by 12 separate resolutions for its demeaning language. The AMA has already clarified that the penalties described in this statement apply only to the written diagnoses and not to clerical coding errors.

Responsible professionals object to daily reiteration of their honesty. Compulsory Medicare assignment, which many thought had been laid to rest last December, resurfaced in Congressional hearings during the meeting. Reaction was swift and vociferous. "The price of liberty is external vigilance."

The problem of equitable reimbursement for cognitive services generates increasing discussion but seems no closer to solution. Several state societies have voted for "more equitable reimbursements for physicians' cognitive services". The House of Delegates voted for a six month AMA study.

Hospital-medical staff relationships received much concern in both the Hospital Medical Staff Section and the House of Delegates. Attorneys for the California Medical Society gained much sympathy by challenging the opinions of AMA legal staff on medical staff by-laws. Atty. John Horty, who had a hand in some of our local medical staff by-laws, was characterized as an outmoded extremist. Unilateral revision of medical staff by-laws by hospital trustess was condemned with enforcement throught JCAH. The protection of quality patient care continues to be the focus as the status of limited licensed practitioners, credentialling, and local ethics committees were discussed. Substitute Resolution 86 clearly expressed the need for cooperation between hosptial management and medical staff in data exchange, costs, and coding accuracy.

Professional liability insurance generated more discussion than anticipated. In line with the news that the Mass. JUA is 180 to 300 million dollars in default, a "crisis of affordability" has been identified in many states. Some physician-owned companies are headed for disaster and no-fault compensation is being explored again. Delegates defeated a request for federal legislation and voted for further study.

Among other subjects, a "National Vaccine Injury Compensation Program", long championed by our delegate John Ayres, has finally come to pass. Passive automotive restraints were recommended for all new automobiles and seat belts for all school buses and public vehicles.

Your AMA is active in so many areas and promoting both physicians' and public welfare so well that you can be proud of your membership. You can add to this activity by expressing your opinions through your delegates, participating in the component societies, and convincing your colleagues to join the ranks of the committed.

Garry deN Hough, III, M.D.
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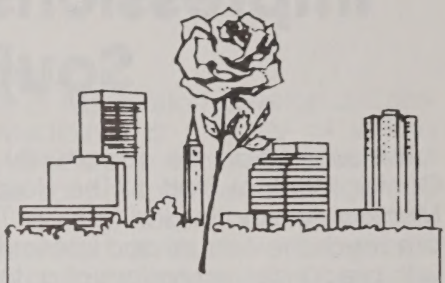

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Impressions of an AMA Soujourn

This June I had the opportunity to represent the Baystate Medical Center Medical Staff at The Hospital Staff Section of the American Medical Association in Chicago. This newly established event directly preceeds the Annual and Interim Meetings of the association. Armed with preconceived notions of a stodgy, unresponsive organization, incapable and unwilling to address the pressing issues of today's medical dilemmas, I headed out one Thursday evening to the Windy City. Certainly, the concept of an organization to address the problems of hospital medical staffs with usurpation of staff authority, the staff's legal status, and a myriad of other problems was laudable. But after attending two meetings of the Massachusetts Medical Society's fledgling organization, I had no real hope that anything of importance could be accomplished.

The Mass. Society's Hospital Staff Section is developing direction and organization at the present time. We have spent time looking for direction and helping to inform our membership understand the problems facing all of us across the state and the nation. Under the able guidance of Percy Wadman, we broached staff anatomy, JCAH requirements and the development of data bases to understand how to deal with our better organized counterparts in the insurance industry and hospital administration. Fledgling, however, we are, and I was in no way prepared, though certainly refreshed and invigorated, to discover that other parts of the country were light years ahead of us in organization and direction.

The Hospital Medical Staff Section was developed to obtain more input from our physicians, who interact with hospitals on a regular basis, to the AMA. With it meeting prior to the House of Delegate Assembly, the section has the opportunity to impact current problems immediately to the AMA for resolution rather than the three months necessary normally for resolutions to reach the floor — and impact it did! Seventeen resolutions from the Staff Section were heard in AMA reference committees. Ten were adopted. Three were adopted as substitute or amended resolution; three were referred to the Board of Trustees and only two were not adopted.

In the start of the Section's second year, I was impressed with its organization, its articulate leadership and its vigor. A forum is, indeed, present for our problems in everyday practice. We are not alone. We must, however, begin to actively participate if our voices are to be heard. There is no longer time to act in righteous self-indignation to the intrusion into medicine by ill-equipped, albeit well-meaning, hospital administrators and bottom line readers of the bill — the rationers in the insurance industry. Obtain information from your hospital staff representative to the section and help in giving this new conduit support. Contribute and participate!

THE SPECIFIC RESOLUTIONS

Resolution: 166
Subject: AMA Medical Ethics Commission
RESOLVED, That the American Medical Association develop a Commission on Ethical Problems of Medicine, a majority of whose members are practicing community physicians, with the remainder of its membership drawn from medical school faculties and from the fields of law, philosophy, sociology, nursing, hospital administration, humanities, government, and from representatives of relevant groups of lay people in order to provide practicing community physicians and their patients with expert, unbiased, and relevant information and guidelines in the difficult and important area of medical ethics.
ACTION: NOT ADOPTED

Resolution: 167
Subject: Donor Organ Study
RESOLVED, That the American Medical Association study means of increasing the availability of donor organs in this country, and report back to the House of Delegates at the 1984 Interim Meeting.
ACTION: SUBSTITUTE RESOLUTION 167 ADOPTED (as above)

Resolution: 168
Subject: Trauma as Alcohol Related Disease
RESOLVED, That the American Medical Association recognize injuries requiring medial care as one of the most serious of alcohol related conditions, and be it further
RESOLVED, That the AMA support designation of taxes from alcohol sales for the prevention of alcohol abuse.
ACTION: REFERRED TO BOARD OF TRUSTEES

Resolution: 169
Subject: Imposition of Financial Penalties on Patients Obtaining Second Opinions
RESOLVED, That the American Medical Association take appropriate measures to inform its membership and the public as to the present status of mandatory second opinion programs and their potential quality and fiscal impact.
ACTION: ADOPTED

Resolution: 170
Subject: Coordination of Insurance Premiums
RESOLVED, That the American Medical Association encourage coordination of total family health insurance premiums paid to insurance companies to reflect the concept that total premiums paid should accurately pertain to the benefits actually given.
ACTION: ADOPTED

Resolution: 171
Subject: Physician Profile and the Prospective Payment System
RESOLVED, That the American Medical Association work to ensure

that evaluation of physician performance resulting from Diagnostic Related Group physician profiling will be through an appropriate committee of the hospital and medical staff which will have access to the raw data and will participate in the development of the data system.
ACTION: REFFERRED TO THE BOARD OF TRUSTEES

Resolution: 172
Subject: AMA Matching Fund for Community Hospital Physician Continuing Medical Education
RESOLVED, That the American Medical Association, through its Council on Medical Education, study means whereby the AMA can assist community hospital medical staffs in reducing the increasing financial burden of supporting first rate continuing medical education programs, and that special attention be given to the plight of the staffs of small rural hospitals.
ACTION: ADOPTED AS AMENDED WITH TITLE CHANGE (Community Hospital Continuing Medical Education)

Resolution: 173
Subject: Proposed PRO Sanctions
RESOLVED, That the House of Delegates direct the American Medical Association to take what further action it deems necessary to affect an appropriate change in proposed regulations, published in the Federal Register in April 18, 1984 entitled "Imposition of Sanctions on Health Care Practicioners and Providers of Health Care Services," to render them fair, adequate and constitutional.
ACTION: ADOPTED

Resolution: 174
Subject: Hospice Program Regulations for Medicare Qualification
RESOLVED, That the American Medical Association continue to work with Health and Human Services and Health Care Financing Administration to modify the Hospice regulations, such that it will be reasonable for organizations to qualify as Hospice Programs under Medicare.
ACTION: ADOPTED

Resolution: 175
Subject: Medical Staff Self-Government
RESOLVED, That the American Medical Association go on record that the hospital governing board bylaws not contain provisions whereby the hospital corporate board or administration could unilaterally amend the medical staff bylaws or its rules and regulations; and be it further
RESOLVED, That the AMA Commissioners to the Joint Commission on Accreditation of Hospitals be instructed to incorporate this into the Joint Commission on Accredation of Hospitals standards.
ACTION: ADOPTED

Resolution: 176
Subject: Legal Status of the Medical Staff
RESOLVED, That the American Medical Association review documents prepared by state medical societies' legal counsel on the legal status of hospital medical staffs, prepare a document suitable for nationwide use, and distribute the document to the members of the House of Delegates and to each state medical society prior to the 1984 Interim Meeting.
ACTION: SUBSTITUTE RESOLUTION ADOPTED (as above)

Resolution: 177
Subject: Medical Staff Bylaws
RESOLVED, That the American Medical Association support as policy that:

1. The medical staff bylaws, rules and regulations shall be initiated and adopted by the medical staff and shall establish a framework of self-government;
2. The medical staff shall govern itself by these bylaws, rules and regulations which shall (a) be approved by the governing body, whose approval shall not be unreasonably withheld, (b) be reviewed and revised as necessary to reflect current medical staff practices, and (c) define the Executive Committee of the medical staff whose members are selected in accordance with criteria and standards established by the medical staff; and
3. The medical staff shall have authority to approve or disapprove all amendments to medical staff bylaws, rules and regulations; and be it further

RESOLVED, That the AMA direct its Commissioners to the Joint Commission on Accreditation of Hospitals Standards.
ACTION: ADOPTED AS AMENDED IN LIEU OF RESOLUTIONS 24 and 72

Resolution: 178
Subject: JCAH Standards Should Require Giving Bylaws to Applicant
RESOLVED, That the American Medical Association encourage hospitals and their medical staffs to make complete sets of medical staff bylaws, rules and regulations available to all medical staff members and applicants who request them.
ACTION: SUBSTITUTE RESOLUTION 178 ADOPTED (as above)

Resolution: 179
Subject: JCAH Standard IV Should Not Tie Clinical Privilege Termination to Contract
RESOLVED, That the American Medical Association urge its commissioners to the Joint Commission on Accreditation of Hospitals to work for inclusion in its Standards of the policy that medical staff bylaws not contain language stating that clinical privileges of contract physicians will automatically be terminated if their medical contract terminates.
ACTION: REFERRED TO BOARD OF TRUSTEES FOR STUDY AND REPORT TO THE HOUSE OF DELEGATES AT ITS INTERIM 1984 MEETING.

Resolution: 180
Subject: Only Physicians on Medical Executive Committees
RESOLVED, That the American Medical Association establish the policy that only physicians should be on the Medical Executive Committee; and be it further
RESOLVED, That the AMA commissioners work for incorporation of this policy into the Joint Commission on Accreditation of Hospitals standards.
ACTION: NOT ADOPTED

Resolution: 181
Subject: Non-Physicians Voting on the Medical Staff
RESOLVED, That the American Medical Association oppose any regulation that would mandate voting privileges for non-physicians members of medical staffs.
ACTION: SUBSTITUTE RESOLUTION 181 ADOPTED (as above)

Resolution: 182
Subject: Rights of Committees of Medical Staffs to Meet in Executive Sessions
RESOLVED, That the American Medical Association support the right of any hosptial medical staff committee to meet in executive session with only voting members of the medical staff present in order to permit open and free discussion of issues such as peer review, and to maintain confidentiality; and be it further
RESOLVED, That individual medical staffs be encouraged to incorporate provisions to accomplish these objectives into their medical staff bylaws.
ACTION: ADOPTED WITH TITLE CHANGE (as above)

Resolution: 183
Subject: Labeling of Generic Drugs
RESOLVED, That the American Medical Association request that all generic medications have an identifying number or symbol.
ACTION: ADOPTED AS AMENDED (as above)

A SPECIAL "THANK YOU" to Dr. Garry Hough and Dr. Gus Siragusa whose guidance made the introduction to the AMA a rewarding experience.

Gregory A. Slachta, M.D.
Delegate, Medical Staff Section
AMA

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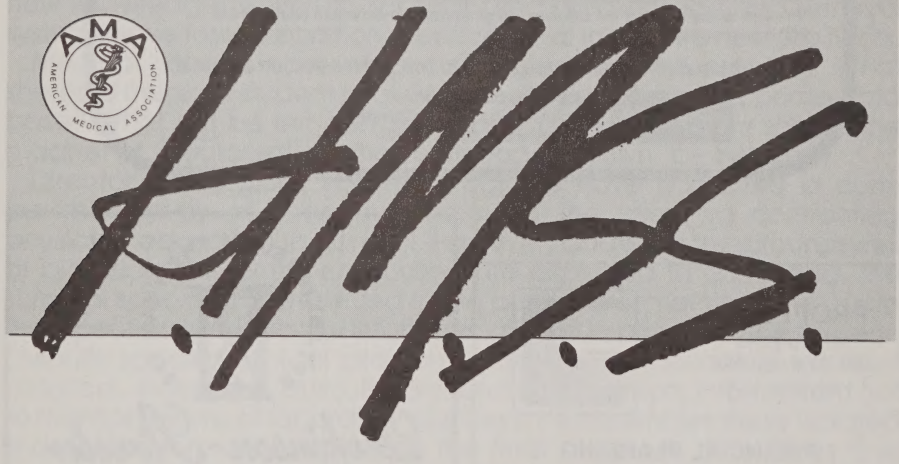

AMA Hospital Medical Staff Section
Fourth Assembly Meeting
November 29-December 3, 1984
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Hospital Medical Staff Services
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Chicago, Illinois 60610
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Thoughts on the Teaching Surgeon

by David W. Page, M.D., F.A.C.S.

In the beginning there was precious little training at all for the surgeon. A presumptuous blade coupled with bold indifference to suffering must surely have counted in the order of a surgeon's efforts — that is, back in the days when John Hunter scoured London's back alleys for anatomic specimens. Througout medicine's history, new, exciting facts emerged swiftly and a requisite arose to transmit the evolving information without transmuting it. In addition, the surgical neophyte must master intricate motor skills. And, while Halsted remains the exalted "father" of our American surgical training system, new knowledge as well as sophisticated data storage and retrieval systems have tossed traditional educational ideas into necrotic knots.

Medical Schools have always struggled with the problem. What should a medical student know? Who will select the appropriate data base? What will be left out? How early in the curriculum should the magnet of specialization, the subtle tug of elitism, be heeded?

Directors of surgical training programs have harvested a comparable covey of concerns, matching the dilemma confronting physician education in general. However, added to the groundswell of biomedical information doctors are expected to command, the surgical specialist is presented to the public as something even more therapeutically awesome. Infallable, at least in principle, the surgeon assaults specific clinical problems, sorts out complicated snarls of historical, palpatory, auscultatory, and other sensory information, not to mention reams of laboratory numbers. He assembles these isolated shards of information to create the final diagnosis. How does one create such a cognitive machine who can also wield a knife?

Mature surgeons aren't retrieved from a special holding area, can't be plucked from a vine, and aren't assembled from a list of individual components. Surgeons can't assimilate megabytes of information, nor can they store and retrieve data flawlessly. No matter how delicate the surgeon's touch, he or she isn't a well-lubricated machine, although like most machines, he or she is subject to predictable breakdown if worn parts aren't rested. Surgeons are molded from the raw stuff of youth, from the eager energy and untainted hopes of men and women whose gaze is celestial and whose minds, for as long as reason prevails, remain open. Training a surgeon necessitates the offering of huge amounts of information, the honing of sensory and motor skills, the cultivation of compassion, the tempering of a broad-based cultural sensitivity, the nurturing of an intrepid spirit.

To foster a perceptive, responsible clinician, the surgical resident must be nudged, not smothered in the name of teaching. Because the resident relieves the surgeon of a portion of his work burden, the

teaching surgeon possesses a useful payback method in allowing the resident to participate in the care of his patient. However, all too frequently surgeons and residents harbour the obsolete notion that an entire case must be handed over to the resident. A sense of unity is apparently lost if the trainee doesn't incise the skin, remove the offending organ, and close, singlehandedly. This all-or-nothing approach precludes participation by more junior residents and tosses senior residents into action for which they may not be properly prepared. In some university programs, residents weave through five years of surgical training in a trial-and-error (trial-and-terror) experience, grasping frantically at bits of information discarded by the resident a mere year advanced in the program.

So called "ward" cases, waifs dragged from the raw reality of the street, directly into the life of the surgical resident, have decreased over the years. Coupled with the spawning of a potpourri of third-party payment schemes and snagged with the consuming cloak of litigation, teaching opportunities for the residents depend heavily upon the good will of the private surgeon. Whether the patient is private or unreferred, the implication for a teaching surgeon remains unaltered. As the resident demonstrates a grasp of historical nuances, identifies physical disease, culls lab data and performs special procedures — he or she must turn, even if haltingly, to the knife. In the hushed compression of time beneath the lights, the issue of training a surgeon becomes focused. All circumlocutory asides regarding options, procedure controversies, personal preferences, dissolve in the solvent of immediacy. The teaching surgeon must maintain control as the resident grasps the knife, cuts into the fabric of the skin.

Now, the knot of bowed heads reveals their intimate personalities. Here lies the full measure of a surgeon's control. Role reversal lies at the epicenter of surgical learning. Beyond reading, observing, retracting, the resident must now perform. In the unblinking glare of the scooped, overhead lights the resident stands alone before a verteran audience eager to correct, an audience all too amnestic of terrified trembling fingers, of distant dissections in faraway operating theaters. Teeming with technical details, hurriedly remembered anatomic minutiae, the surgical resident lowers the knife, cutting into human flesh, violating the most sacred covenant. There can be no faltering, no blunder as he denies the primitive instinct to flee. Within millimeters of vital tissues, the resident pushes ahead, perhaps stung by reproach, none-the-less resolved, even if the case turns sour for the moment as operations are wont to do.

Who assures nothing will go wrong? The responsibility lies with the teaching surgeon, who also performs, providing the resident with skills to mimick, knowledge to commit to memory, standards to emulate. And, in the crucible of the operating room, the teaching surgeon learns. Across the narrow table, he steals from the resident, whose knowledge in novel, budding clinical specialties exceeds that of the surgeon. It is a wonderous process. The resident dissects. he spreads the tissues in search of delicate structures, performing a programmed hand ballet, a tightly orchestrated sequence of movements which

have evolved through the centuries and which are re-lived in mere moments.

By providing distinct parts of a surgical procedure rather than expecting a resident to fumble through a case, the teaching surgeon maintains control, maximum efficiency, and assures patient safety. At least one reported series confirms that strict supervision of the resident results in outcomes indistinguishable from those obtained by the teaching surgeon operating as the primary surgeon. The process must not be permitted to wither in the heat of restructured reimbursement schemes. Our children must be assured quality surgeons; for, as Robert Frost said, summing up a life of profound thought: "Life goes on." So must our dedication to teaching our surgical charges.

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Notes and Quotes of Interest

Chrysler Corporation pays $373 million a year for health insurance, causing $600 to be added to the price of each car it produces.

Errors in more than 9 out of 10 hospital bills from 40 states reviewed in 1982 by a national auditing firm, reports the HIAA. Most errors were in favor of the hospital, but more than 3 out of 4 bills charged for services never rendered to the patient.

The Hampden District Medical Society Auxiliary announces its Shared Concerns Symposium, "Quality Medical Life" on October 31, 1984 at Vincents Steakhouse.

Anita D. Taylor, M.A. Ed., author of numerous publications and co-author of **Couples - The Art of Staying Together** will be the guest speaker.

The goal of this presentation is to provide an overview of medical family life and specific methodologies to achieve optimum quality.

Circle the date and watch the mail for further details. Program co-ordinator for this event is Mrs. Lorraine Penhos.

The Massachusetts Medical Society honored three Western Mass journalists on June 27, 1984 for their excellence in communicating health information, the Springfield Union reports.

Laurie Bobskill of the Daily News in Springfield won first place in the over 50,000 circulation for her series on flouridation, and Colleen Fitzpatrick took a first place in the under 50,000 circulation group for "An Autopsy: Searching for 'Why' " published in the Daily Hampshire Gazette.

A citation of merit was awarded to Barbara Dolan of the North Adams Transcript.

Congratulations to Dr. & Mrs. Philip Stoddard on the birth of a baby girl, Ashley Elizabeth, July 16, 1984.

The **Baystate Medical Center's Department of Surgery** is sponsoring a Symposium on "The Dilemma of Treating the Patient with Myocardial Ischemia" September 10, 1984 at the Marriott Hotel in Springfield. Outstanding experts from all parts of the country will participate.

On **Monday evening, October 22, 1984** from **7 - 9:30 P.M.,** at the Greek Cultural Center, 8 Plain Field Street, Springfield, the Junior League of Springfield, Inc., the League of Woman Voters of the Springfield area and TAPPA (Teenage

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Pregnancy and Prevention Alliance) will be sponsoring a public forum entitled **SEXUALITY EDUCATION: WHOSE RESPONSIBILITY IS IT?** Dr. Sol Gordon, nationally known writer, lecturer and educator who is currently a professor of Child and Family Studies at Syracuse University will be the guest speaker. Along with having written several books on the topic of sexuality and sexuality education, Dr. Gordon has also appeared on several popular talk shows, such as the Today Show, the Phil Donahue Show, and Sixty Minutes.

The focus of the forum will be to fascilitate discussion within the community on this important topic. Following Dr. Gordon's keynote, an aide of Mayor Neal will be introducing a panel of community representatives who will be dealing with the topic of Sexuality Education from different perspectives.

Panel members will include two teens from the Springfield Peer Education Project (PEP), Reverend Warren Savage, educator, Cathedral High School, Reverend Ron Peters, Springfield School Committee, Amina Ali, Director, Project SAFE (Services for Adolescent Family Enhancement), and Sandy Flatow, pediatric nurse practicioner and parent.

The forum will be free of charge. All are encouraged to attend.

Clergyman To Speak At Next Dinner

The Hampden District Medical Society's September District Meeting will feature Msgr. Dino J. Lorenzetti of Buffalo, New York. He will explore the importance of the spiritual need of our patients.

Msgr. Lorenzetti is well qualified to address this subject with physicians. He has been the ecclesiastical chaplain for the International Federation of Catholic Physicians from 1975 to the present. He has also been spiritual adviser for the past ten years for the National Federation of Catholic Physicians' Guild and has contributed regularly to its Linacre Quarterly publication. Msgr. Lorenzetti has also been the Family Life Director of the Archdiocese of Buffalo.

In view of the subject for this District Meeting, the pastoral care persons, chaplains and interested clergy will be invited to attend.

James G. Fitzpatrick, M.D., Chairman
Medico-Religious Committee

Chamber of Commerce - Annual Meeting

On Monday, June 5 the Greater Springfield Chamber of Commerce held its annual meeting at a luncheon at Chez Joseph. It was attended by 550 of the leading businessmen of the area, plus a small contingent from the Hampden District Medical Society who were drawn to the luncheon by its main speaker, Mr. Nelson Gifford, who was discussing business' role in curbing health care costs.

Mr. Gifford is the present chief executive officer of Dennison Manufacturing Company and apparently had a major role in the movement that led to Chapter 372. In reviewing the problem Mr. Gifford first declared that access to medical care is a right, but then went on to redefine that as meaning appropriate care. Mr. Gifford stated that a major problem is that the patient who demands the service does not pay the bill. He reviewed the fact that health care costs have increased from 6% of the Gross National Product to 11% of the Gross National Product in the past 30 years and made the statement that if we were to efficaciously apply medical technology to every situation that would prolong life or prolong death, if you prefer, we would spend 25% of the Gross National Product on health care.

Amongst the problems he highlighted to the attending business leaders were the problem of distinguishing between prolonging life and prolonging death. The problem of post institutional care availability, delay in discharge from hospitals, the wide variability of physician costs, the services being rendered in an inappropriate setting, and an excess of 3,500 hosptials beds in Massachusetts.

He then went on to describe how Chapter 372 was designed to contain "the beast" (that's us). Mr. Gifford pointed out that under Chapter 372 in its first fiscal year hospital billings rose only 8.3% in Massachusetts compared to 12.6% nationally, which is indeed a significant feat. He told his fellow businessmen that other means of controlling health care costs would be explaining the facts of life to employees, encouraging them to accept larger deductables and co-insurance plans, further evaluation of managed care and HMO options and furter funding of wellness and employee assistance programs (EAP programs). Mr. Gifford concluded by reminding the audience that business was part of the problem (in its historical approach to health benefits) and must create solutions to the problems.

Also, at the same meeting, the Greater Springfield Chamber of Commerce announced that the Greater Springfield Health Care Coalition will in the future be hiring a full time staff. Mr. John G. Gallup, President of Strathmore Paper Co., and new Chairman of the Coalition, announced the establishment of a board of overseers made up of the chief executive officers of the 25 largest for profit employers of Greater Springfield.

Each of these 25 companies will have made a financial committment to help hire the staff to develop the kind of data that will allow the Coalition to pinpoint problem areas and in turn cut costs.

Terry D. Ryan, M.D. Co-Editor Hampaen Hippocrat

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In Memoriam

Robert W. Emery, MD died May 11, 1984, in the Springfield Hospital.

After growing up in North Adams, he graduated from Springfield College and Tufts Medical School. He took a surgical residency at Baystate Medical Center and served in the Korean War with a U.S. Army MASH Unit.

He was active in medical and civic organizations, receiving the prestigious Pynchon Award as well as Springfield College's Tarbell Medallion and the Jewish War Veterans' Outstanding Citizen Award.

He leaves his wife, Ruth, five sons, three daughters, two brothers, and 11 grandchildren.

Theodore R. Miner, MD died January 5, 1984, at home.

A native of Brooklyn, New York, he graduated from Dartmouth College and the New York University Bellevue Hospital Medical College.

He served in the U.S. Navy Medical Corps during World War II, both in CONUS and the South Pacific, and after discharge in 1945, served as C.O. of the Naval Reserve Medical Unit in Springfield for 15 years.

He served as Surgeon-in-Chief from 1964-66 at Springfield Hospital Medical Center and was director of emergency medical services at Baystate Medical Center from 1971-74.

He was active in medical associations and took part in many Dartmouth alumni activities, receiving the Dartmouth Alumni Award in 1975.

He leaves his wife Florence, 2 children, a brother and six grandchildren.

Leonard S. Jagoda, MD died May 25, 1984, in a local nursing home.

Born in New York City, he graduated from Creighton University. He served in the U.S. Army Medical Corps during World War II and was chief of anesthesia at the Wesson Unit of Baystate Medical Center before retirement.

He is survived by his son, a brother and a sister.

Welcome New Members

Nicholas P. Spencer, M.D.
130 Maple St.
Springfield, MA 01103

BORN:	August 7, 1950
PREMED:	University of Virginia 1968-72
MEDICAL:	University of Virginia 1973-77
RESIDENCY:	Lahey Clinic, Boston City Hospital 1979-81
SPECIALTY:	RADIOLOGY

Matthew B. Mandel, M.D.
Providence Hospital
Holyoke, MA 01040

BORN:	January 16, 1946
PREMED:	Western Reserve University Cleveland Ohio 1963-67
MEDICAL:	Faculte de Medecine Universite de Tours, France 1967-71 Hahnemann Medical College, Philadelphia 1971-74
INTERNSHIP:	Bryn Mawr Hospital 1974-75
RESIDENCY:	Peter Bent Brigham Hospital 1975-77
FELLOWSHIP:	Boston Hospital for Women 7-77-12-77 Children's Hospital 1-78-6-78
SPECIALTY:	ANESTHESIOLOGY

Spencer Van B. Wilking, M.D.
759 Chestnut St.
Springfield, MA 01107

RESIDENT

BORN:	August 24, 1948
PREMED:	Columbia University, NY 1966-70
MEDICAL:	University of London U.K. 1977-82
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center-present time
SPECIALTY:	INTERNAL MEDICINE

Maria Moutinho, M.D.
300 Stafford St.
Springfield, MA 01104

BORN:	December 10, 1955
PREMED:	University of Iowa 1972-75
MEDICAL:	Meharry Medical College, Tennessee 1976-80
INTERNSHIP:	Baystate Medical Center 1980-81
RESIDENCY:	Baystate Medical Center 1981-83
SPECIALTY:	PEDIATRICS

Ira E. Ross, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	December 14, 1953
PREMED:	Boston University 1972-76
MEDICAL:	Albert Einstein 1976-80
INTERNSHIP:	MT. Auburn Hospital 1980-81
RESIDENCY:	MT. Auburn Hospital 1981-83
SPECIALTY:	INTERNAL MEDICINE

James R. Fletcher, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	December 5, 1947
PREMED:	Florida International University 1976-78 Miami DADE Community College 1975-77
MEDICAL:	University of Miami School of Medicine 1978-82 Jackson Memorial Hospital
INTERNSHIP:	Hartford Hospital 1982-83
RESIDENCY:	Institute of Living 1983-present
SPECIALTY:	PSYCHIATRY

Randolph E. Knob, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	July 7, 1947
PREMED:	Manhattan College Bronx, NY 1965-69
MEDICAL:	Downstate Medical Center, NY 1969-73
INTERNSHIP:	Kings County Hospital Ctr. Brooklyn NY 1973-74
RESIDENCY:	Kings County Hospital Ctr. Brooklyn NY 1974-78
SPECIALTY:	GENERAL SURGERY

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Seth S. Johnston, M.D.
759 Chestnut St.
Springfield, MA

RESIDENT

BORN:	September 30, 1947
PREMED:	State University of NY at Stony Brook 1964-69
MEDICAL:	Sackler School of Medicine University of Tel-Aviv, Israel 1970-76
INTERNSHIP:	NY Infirmary-Beekman Downtown Hosptial, NY 1982-83
RESIDENCY:	Baystate Medical Center 1983-85 present time
SPECIALTY:	INTERNAL MEDICINE

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Whether you are married to a physician in his post graduate training or you are in practice or you've been around and through it all, WE NEED YOU!

The Auxiliary is an organization tailor-made to meet our needs and responsibilities and for our community.

You have the choice of participating in or supporting our community projects. We offer personal growth through our programs, example our Shared Concerns Symposiums. Last but not least, friendship with other physician spouses.

The choice is yours -

To commit yourself to the Auxiliary;
To give as well as recieve;
To create change to be prepared for our future in medicine and our contrubution to the community in which we serve.

Please contact Ginny Walthall, membership chairperson or Elaine Alexander Intern and Resident membership chairperson, c/o Hampden District Medical Society, 1414 State Street, Springfield, MA 01109.

JOIN US - WE CAN DO MORE TOGETHER!

Vicki Kiss

Executive Committee Report

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, May 21, 1984 at the Society's office. The meeting was called to order by Dr. Lorne Smith, President, at 7:30 p.m.

Present were: Drs. Smith, Asinas, Walthall, Remsberg, O'Neill, Pacosa, Ryan and Hough; Mrs. Vicki Kiss representing the Auxiliary, and Mrs. Nystrom. Dr. Prybylo of the Health Care Committee was also present.

The minutes of the April 9, 1984 meeting were accepted as mailed. The Springfield Academy of Medicine Financial Report for April, 1984, was accepted.

Dr. Smith thanked Dr. O'Neill for a successful Legislative Breakfast. The breakfast was held on May 18, 1984 at the Sheraton West in West Springfield. Members of the Legislative Committee, Executive Committee and the HDMS Auxiliary acted as hosts. There were eleven legislators present and the discussion that ensued was very productive.

Mrs. Kiss said the Auxiliary was planning to hold an all day workshop in October on Professional Family Life. The Society offered to co-sponsor this program. Announcements will be published in the HDMS Newsletter and the Hampden Hippocrat.

Dr. Hough said the Greater Springfield Health Care Coalition was at a point where he would like to see some new directions given to the Steering Committee. Dr. Hough felt the doctors should be selecting some short and long range goals for presentation to the Steering Committee. Dr. Hough will send a letter to physicians on his Health Care Committee asking them to write one short term and one long term goal that they feel should be recommended to the Steering Committee.

It had been reported to Dr. Smith that the City of Springfield was using a chiropractor to do physicals for employees. Dr. Smith felt this topic should be considered by the Society's Public Health Committee.

Policy on legislation and news releases was discussed. Responses to articles and media questions should be immediate. Our policy on legislation should be aggressive and on-going. The Public Relations Committee will coordinate the Second Opinion Newspaper Column. The media will be sent a list of physicians to contact to get specific answers to medical questions.

Dr. Ryan said the Hippocrat Editorial Board would like to change to a larger issue and publish six times a year. The Executive Committee was agreeable to this suggestion.

There being no further business, the meeting was adjourned at 9:05 P.M.

Respectfully submitted,

William W. Walthall, Jr., M.D. Secretary

Executive Committee Report

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, June 25, 1984 at the Society's office. The meeting was called to order by Dr. Lorne Smith, President, at 7:40 p.m.

Present were: Drs. Smith, Asinas, Walthall, Remsberg, Pacosa, Stoler, Hutt, Hough, Ryan and Mrs. Nystrom. Dr. James Fitzpatrick, Chairman of the Medico-Religious Committee was also present.

Dr. Smith welcomed Dr. Stoler and Dr. Hutt to the Executive Committee.

The minutes of the May 21, 1984 meeting were accepted as printed. The Springfield Academy of Medicine Financial Report for May, 1984, was accepted.

Dr. Fitzpatrick outlined his plans for the September District Meeting with the committee.

Oak Manor Nursing Home had written asking physicians to comply with required timely visits to nursing home patients. Dr. Smith will address this issue in the Hippocrat.

Dr. Smith gave an informational report on reaction to a recent Hippocrat article referring to Senators Melconian and Reilly.

Discussion centered on state reports of high infant mortality rates in the Springfield/Holyoke Area. Independent actions to evaluate and improve these rates have been started. Dr. Gold, Chairman of the Public Health Committee, will be asked to investigate and report in the Hippocrat on this subject.

A local Chapter of the American Association of Retired Persons had written requesting names of physicians who have a special interest in the care of the aged. A notice will be put in the Hippocrat asking doctors to call the Society's office if they wish to be on the list.

Dr. Hough reported on the AMA Annual Meeting held earlier this month.

There being no further business, the meeting was adjourned at 9:30 P.M.

Respecfully submitted,

William W. Walthall, Jr., M.D.
Secretary

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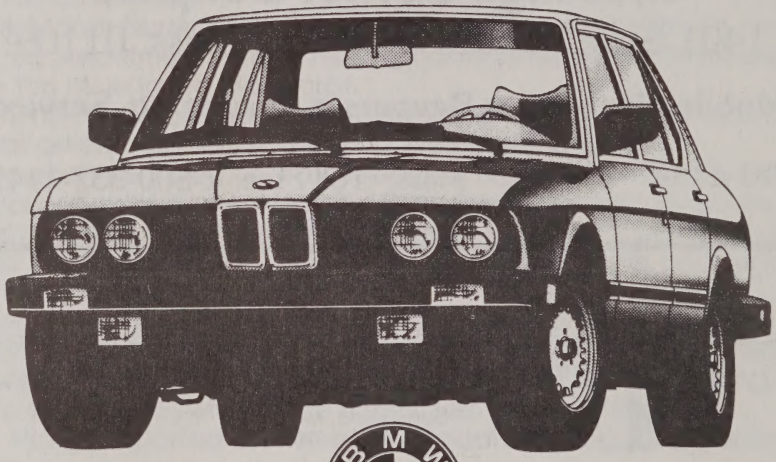

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